Payment Reform Stakeholder Survey

Individual Responses

|< < 77 / 100 > >| 77 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

None

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Terminal illnesses. Patients are referred to hospice at a late time during the disease process. These patients are undergoing aggressive treatment and therapies that in most cases are futile. Medicaid could save this money if physicians would provide explanation to the patients about options involving end-of-life care. Perhaps they could even be reimbursed for this. The hospice medicaid benefit saves medicaid money.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Hospice care is the gold standard of care for patients at the end-of-life. If more patients were informed about this option and chose hospice it would allow patients and families to receive compassionate high quality care that is delivered in a cost effective manner. A study commissioned by the National Hospice and Palliative Care Organization and conducted by Millman USA, showed that hospice saves state Medicaid programs approximately $7,000.00 per Medicaid hospice beneficiary. This is done through preventing unnecessary hospitalization, providing medical equipment and supplies under hospice and reducing the amount Medicaid pays for terminally ill patients residing in a nursing home (in Arkansas that amounts to almost $1 million in savings.)

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

The biggest challenges are with physicians informing patients about this benefit. Patients may not know about hospice or may have preconceived ideas about what hospice care provides. If physicians could be reimbursed for having these conversations, maybe they would be more willing to spend the time.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

This is a promising area because it could be implemented easily with very little expense to Medicaid. Medicaid would potentially save money for each patient enrolled in hospice.

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

Sebastian

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Jim Petrus

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < 77 / 100 > >| 77 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 78 / 100 > >| 78 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

CHCs are/have/provide : • patient centered medial homes • model of care • integrated team approach • patient centeredness • clinical quality outcomes-care model, model for improvement, health disparities collaborative • use of EHRs • cost savings to Medicaid o prevention of unnecessary hospitalizations o prevention of inappropriate use of emergency room o prevention of unnecessary and inappropriate specialty care referrals

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

• Care coordination • Navigators • Local available and accessible resources..walking trails, wellness centers, specialists • Providers who are culturally and literacy sensitive, etc • Patients who are compliant • Education materials that are culturally, literacy, linguistically appropriate

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

• Lack of preventive care/coverage for children and their parents, especially lack of coverage availability for legal immigrant children, particularly the Marshallese (state option to remove the 5 year bar that exists for legal immigrant kids), who cost taxpayers more as they are treated for avoidable disease or complications • Red tape and cumbersome processes that hinder enrollment and *ESPECIALLY* renewals, where thousands of kids drop off and then cost the system more as they churn on and off coverage. Technology could play an important positive role here, not to mention in coordinating service systems and health care providers. • New opportunities to provide preventive dental care to kids (e.g. physicians), as was authorized during the recent legislative session • Opportunities to offer preventive care in new settings and reach children/families who are not connected to a medical home (e.g. schools) and bring them into the health system. • Wasted time/process/duplication that occurs with referrals, provider "handoffs" etc.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Health System Administrator

8. Please select your county of residence:

Madison

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide

identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 78 / 100 > >| 78 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 79 / 100 > >| 79 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

In addition to addressing the list provided you could also include input that includes that CHCs are/have/provide : • patient centered medial homes • model of care • integrated team approach • patient centeredness • clinical quality outcomes-care model, model for improvement, health disparities collaborative • use of EHRs • cost savings to Medicaid o prevention of unnecessary hospitalizations o prevention of inappropriate use of emergency room o prevention of unnecessary and inappropriate specialty care referrals

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Specility care/sub specility care referrals Lab, x-ray, unnecessary tests, discharges, patietnts fall betweent he cracks, orthopedic patietns needing rehab., patients with both physical and mental needs

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

• Care coordination • Navigators • Local available and accessible resources..walking trails, wellness centers, specialists • Providers who are culturally and literacy sensitive, etc • Patients who are compliant • Education materials that are culturally, literacy, linguistically appropriate

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

• Lack of preventive care/coverage for children and their parents, especially lack of coverage availability for legal immigrant children, particularly the Marshallese (state option to remove the 5 year bar that exists for legal immigrant kids), who cost taxpayers more as they are treated for avoidable disease or complications • Red tape and cumbersome processes that hinder enrollment and *ESPECIALLY* renewals, where thousands of kids drop off and then cost the system more as they churn on and off coverage. Technology could play an important positive role here, not to mention in coordinating service systems and health care providers. • New opportunities to provide preventive dental care to kids (e.g. physicians), as was authorized during the recent legislative session • Opportunities to offer preventive care in new settings and reach children/families who are not connected to a medical home (e.g. schools) and bring them into the health system. • Wasted time/process/duplication that occurs with referrals, provider "h

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Other, please specify
Operations Director

8. Please select your county of residence:

Arkansas

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

COMPANY:
Community Clinic

ADDRESS:
614 East Emma Suite 300

CITY:
Springdale

ZIP:
72764

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 79 / 100 > >| 79 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 80 / 100 > >| 80 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Several of the priority items that the Department has identified require medically necessary eye examinations provided by eye care professionals as part of the continuum of care. Optometrists provide the appropriate care necessary for resource intensive patients that would typically fall within the disease states listed. Including optometry within the episode coordinating body will get those patients the necessary care through local community based providers who contribute these services now and can assist the coordinating body with continued follow up with patients. Diabetic eye care: Current research indicates that all newly diagnosed diabetics between the ages of 18-75 should be referred for a baseline comprehensive eye exam. Thereafter, diabetics should be seen at least every year especially those who are considered high risk (diabetics who are on insulin, have a hemoglobin A1C value of >8.0, or history of previous diabetic retinopathy). Diabetics are at a high risk for retinal disease. Yearly examinations by an eye care professional would provide feedback regarding the presence/severity of retinopathy (and resultant vision loss) and should help guide the aggressiveness of systemic care provided by the primary care provider. Diabetes is a perfect example of how healthcare professionals can work together for the betterment of the patient. Optometrists are typically one of the first healthcare professionals to see diabetic patients (through the detection of diabetic retinopathy) and having the ability to communicate with a primary care provider to track that person into coordinated care permits an earlier intervention in the disease and provides an opportunity for better and less intensive management of that patient. The goal of an episodic payment is to better manage a patient so that they receive the appropriate care more efficiently. Having a trained professional providing a basic area of care is the very definition of providing appropriate, efficient care. Hypertension: Similar to diabetics, those with primary or secondary hypertension should be referred for a baseline eye exam, with additional examinations that would be coordinated by the primary care provider to detect the presence and/or stage of hypertensive retinopathy. Activities of Daily Living: Those with permanently reduced vision from the above conditions, or others such as macular degeneration are often underserved. Optometrists specializing in low-vision care should provide services that emphasize coping strategies/devices that reduce dependency on other care providers. This service can be combined with other therapeutic services to allow beneficiaries to continue to live full and productive lives. Providing continual, medically necessary therapeutic services within an episode is the most efficient use of those services. Ischemic heart disease: Again while initial referrals from primary care providers are necessary to initiate necessary eye care, the utilization rate should be guided by condition severity and identification of associated ischemic eye disorders like ocular ischemic syndrome and glaucoma.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Auto-immune/Connective-Tissue Disease: This population is underserved and largely under-referred by primary care physicians and rheumatologists to eye care providers. With the high prevalence of associated ocular conditions (i.e. iritis, dry eye syndrome), referral for preventative and primary eye care for this population could reduce the overall utilization rates and treatment costs that are incurred when eye care is not initiated until late in the disease process.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

As stated above, recognizing that integrated eye care is vital to the proper management of diabetes, hypertension, ischemic heart disease and auto-immune/connective-tissue disease is the first step. Utilizing current guidelines and quality measurements and making certain medically necessary eye exams are properly delivered to the patients in a timely and efficient manner can be important in terms of both health outcomes and cost of care. Ensuring providers like optometrists and primary care providers are able to communicate the results of medical tests or exams that are necessary to properly manage a patient will be essential to success. The state will need to ensure all providers are properly integrated within the state's health information technology plan, specifically the information exchange. This will require the state include all types of providers within the exchange and that all due diligence is done to make all providers eligible for Federal electronic medical record incentives like the Medicare and Medicaid incentive. Finally, the

state should work with provider organizations such as the Arkansas Optometric Association to ensure there are sufficient providers delivering care and work with our organization to help further integrate eye care professionals into the continuum of care.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

The Arkansas Optometric Association cannot stress enough that upon diagnosis of conditions with known ocular manifestations, patients need to be referred for baseline and routine eye care to reduce expenditures associated with end-stage disease process. Having eye care professionals as part of the episodic coordinating entity, and integrating them into the infrastructure that will be necessary to coordinate this care, is vital to achieving the goals laid out by the Governor. The state will need to work with its partners in the payer and employer community to better educate patients and other providers about the roles each type of provider plays within an episode. For example, some EMR programs, like the CPRS program used in the VA, aids providers with built-in notifications to provide a certain type of examination or therapeutic service. This system could be used to direct a primary care provider or a case manager to refer a diabetic patient to a local participating optometrist for a baseline eye exam. Maximizing these features could increase the likelihood that coordinated care is achieved between health care providers. In addition, we should be working with various provider groups to help better define their roles within the continuum of care and creating better guidelines on when a patient should be referred to an optometrist and when an optometrist should refer a patient back to primary care provider. While this seems obvious, a potential problem with coordination of care is limiting the participation of certain healthcare professionals within the system rather than utilizing them to the full extent of their ability. Additionally, the state could go a long way to facilitating better integration of care through very public recognition of all healthcare providers beyond just doctors of medicine and osteopathy. It would be helpful to have the state recognize all healthcare providers are necessary parts of the provider team and need to be consulted and integrated throughout the entire development process. This could aid in the likelihood of success and satisfaction of the program.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

The best place for the program to start is better integrated care for diabetic patients. All of the pieces are currently in place and the research has already been done to improve diabetic management through the proper allocation of care for patients in the system. Additionally, there is an established provider base already performing the needed care for these patients. There is a good base to work from to increase efficiency and outcomes of care.

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Other, please specify
Arkansas Optometric Association

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Tim Elcyzyn, O.D.

COMPANY:
Arkansas Optometric Association

ADDRESS:
816 Miller Cove

CITY:
Benton

ZIP:
72019

EMAIL:
telcyzyn@yahoo.com

PHONE NUMBER:
918-346-2511

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 80 / 100 > >| 80 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 81 / 100 > >| 81 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Our focus remains offering access to as vast amount of patients as possible.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Preventive dental care for children should be made more accessible. Also, children remaining eligible for Medicaid/ARKids is sometimes a problem as they are taken on and off the rolls.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

I have gotten information that less than 40% of children receive EPSDT screens from their PCP. We have children coming to our mobile facilites who have not had EPSDT screens and we cannot do them and be reimbursed. Could the system be changed to allow providers other than the PCP do EPSDT screens and be reimbursed?

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

I'm sure private providers would be opposed but the bottom line is that most of Arkansas' children are not getting this important service.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Explain situation to elected officials and have PCP policy changed as it relates to EDSDT screening.

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Other, please specify
CEO

8. Please select your county of residence:

Lee

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Clifton Collier

COMPANY:
Lee County Cooperative Clinic

ADDRESS:
P O Box 669

ADDRESS 2:
530 W. Atkins Blvd

CITY:
Marianna

ZIP:
72360

EMAIL:
ccollier@lccc.us.com

PHONE NUMBER:
870 295-5225, ext 103

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 81 / 100 > >| 81 GO

Payment Reform Stakeholder Survey

Individual Responses

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

• There are significant issues with the availability of PCP providers in many areas of the state. All areas require significant increases in preventive education/supports and coordination of care. • The impact of not addressing some key needs realistically, result in substantial costs in other areas. Prevention is one of these; also substance abuse and the needs of those with significant developmental disabilities, especially for those with mental retardation or low functioning. • Children's mental health services require more services and supports as defined in the work of System of Care. Prevention here too is critical. School services need to be addressed. realistically. All behavioral problems are not mental health issues and children may be harmed by such diagnosis. Schools do need help. This is a statewide issue. (Positive behavioral supports might go a long way. There continues to be 1) a need to increase facility admission prevention and early intervention, 2) support the transitions from residential programs back to the community, and 3) support youth transitioning back to the community. • There is a need for quality "case management." Case management is cost effective for those at risk of repeated hospitalization, especially for those who are seriously/chronically mentally ill and need psychiatric hospitalizations. Dental care and its relationship to other health concerns.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

• Children: There are "some" residential programs and DDS/DDTS centers for whom increased monitoring should be explored. There are "some" recruitment, qualifying and treatment practices that are not in the best interest of those served and increase expenditures. • Fraudulent practices need to addressed head on. • Physicians need to be encouraged to assess substance abuse across all populations. It is not addressed in most settings, not even in obstetrics where the relationship between alcohol, nicotine and other drugs and increased neonatal costs and life-long consequences are well documented. • Most of the community mental health centers need to be supported more broadly by the state, without the tie in to Medicaid. It is not cost-effective and placing the existence of key providers in jeopardy. There are services that must be delivered for the well being (and sometimes safety) of our citizens. Using Medicaid to finance so much of mental health is not going to be sustainable. Perhaps the system itself needs to be rexamined.(for profit vs non-profit models) The expansion and improved utilization of community treatment models deserves increased exploration.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Clearly financial incentives need to be re-examined. A wholistic approach to health care must be adopted not just in theory but in practice.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Lack of time for, training of, and reimbursement of preventive approaches. There is not much of an emphisis on best practice or intergrating our systems. Increased coordination across the state's DHS and provider systems.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Prevention: Dietary and substance abuse need to be addressed head on by physicians. Increased emphasis on public health approaches and the engagement of patients in their health care decisions. Increase the availability of care that is evidenced based. Explore options for improving all health care service delivery in underserved areas. Increase discharge planning/supports for all medical and behavioral health services. Modifications in the the EDSDT to identify and address the social-emotional needs of young

children.

6. Please provide any other comments, solutions or suggestions you would like captured.

The effort to consider ways in which the groundwork is developed is appreciated. There must be an examination of what is going to proudce only short-run savings but may not result in long-term savings or could result in in exacerbating problems. There is a need for patients to be involved in their helath care decesions.

7. Please indicate which response best represents you.

Other, please specify
Community organization

8. Please select your county of residence:

Pope

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Carol A. Lee

COMPANY:
Child Development Inc.

ADDRESS:
PO Box 2110

CITY:
Russellville

ZIP:
72801

EMAIL:
clee@childdevinc.org

PHONE NUMBER:
479.968.6493

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 82 / 100 > >| 82 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 83 / 100 > >| 83 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Community Health Centers provide a model of care with the health disparities collaborative with clinical quality outcomes. They use EHR and are a cost savings to mediciad. Community Health Centers will be certified patient centered medical homes.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Specialty care referrals, unnecessary tests, patients fall between the cracks, rehabilitation, patients needing both physical and mental health needs, getting patient information from all providers of care. Lace of preventive care/coverage.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

care coordination, navigators, local resources - transportation issue in rural areas, patient compliance, education materials

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Patient compliance, lack of high speed connectivity, lack of local specialists and resources, transportation

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Technology in coordinating service systems and health care providers. Preventative care and bringing them into the health system before there is a major health problem.

6. Please provide any other comments, solutions or suggestions you would like captured.

Wasted time/process/duplication that occurs with referrals, provider "handoffs"

7. Please indicate which response best represents you.

Health System Administrator

8. Please select your county of residence:

Clay

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Brigitte McDonald

COMPANY:
Corning Area Healthcare, Inc.

ADDRESS:
1300 Creason Road

ADDRESS 2:
P.O. Box 83

CITY:
Corning

ZIP:
72422

EMAIL:
brigmcdonald@yahoo.com

PHONE NUMBER:
8708573399

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 83 / 100 > >| 83 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 84 / 100 > >| 84 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

The Community Health Centers of Arkansas, Inc., the Arkansas Primary Care Association, represents 12 Community Health Centers and their 73 respective locations. In 2010, Arkansas CHCs served 150,669 patients per the Uniform Data System Reports (UDS). In the UDS Report, Arkansas CHCs identified their top diagnoses as hypertension and diabetes. Arkansas CHCs' top diagnoses of hypertension and diabetes are consistent with the identified priorities within the stakeholder community. Arkansas CHCs served over 29,213 hypertensive patients in 2010. Of these patients, over 61% had controlled hypertension. Also, Arkansas CHC patients had over 12,300 diabetic patients. Over 75.5% of these patients have HbA1c less than 9%. Arkansas CHCs have participated in the Health Disparities Collaborative, a program which focuses on achieving excellence through goals such as building strategic partnerships, transforming clinical practice through models of care, improvement, and learning, developing infrastructure, and generating/documenting improved health outcomes. In 2010, Arkansas CHCs improved in every clinical category including diabetes, hypertension, childhood immunizations, cancer screening, and prenatal care. Arkansas CHCs are actively engaged in delivering comprehensive care through integrated team models, which encompasses mental/behavioral health, oral health, and medical services.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

There are an abundance of inefficiencies within specialty and sub-specialty referrals for patient care. For example, there is a concern with the "hand-off" between primary care and specialty providers when referring patients. In many instances, there is not a follow-up mechanism in place to ensure that the patient receives a specialty referral appointment or actually sees the specialty provider. The feedback loop is incomplete due to specialty providers not providing patient medical records to the referring provider. Furthermore, there are additional concerns in potential duplicative services through primary and specialty providers ordering the same procedures for a given patient. Many diseases can be managed in the primary care setting through maximizing the use of the patient-centered medical home integrated team approach. Additional importance is that there are inefficiencies due to inefficient care provided by individual provider, Ineffective diagnostic testing and decisions, ineffective clinical decision making, missed health promotion and prevention opportunities, better patient support and patient engagement, and reducing health care acquired conditions. Additionally, there is a need for hospitals to coordinate a primary care provider assignment for patient discharges. Also, there is: a. Lack of preventive care/coverage for children and their parents, especially lack of coverage availability for legal immigrant children, particularly the Marshallese (state option to remove the 5 year bar that exists for legal immigrant kids), who cost taxpayers more as they are treated for avoidable disease or complications b. Red tape and cumbersome processes that hinder enrollment and *ESPECIALLY* renewals, where thousands of kids drop off and then cost the system more as they churn on and off coverage. Technology could play an important positive role here, not to mention in coordinating service systems and health care providers. c. New opportunities to provide preventive dental care to kids (e.g. physicians), as was authorized during the recent legislative session d. Opportunities to better serve many recipients (Seniors, DDS, mental health system) in communities rather than bed-based settings. e. Opportunities to offer preventive care in new settings and reach children/families who are not connected to a medical home (e.g. schools) and bring them into the health system. f. Wasted time/process/duplication that occurs with referrals, provider "hand-offs" etc.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Our suggestion for improvement is to focus on care coordination, patient navigators, and cultural/literacy appropriate services with a special emphasis on the social determinants of health and patient compliance.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Current barriers include insufficient broadband connectivity resources throughout the state, which has a negative impact on provider EHR adoption and implementation. Patient compliance provides a barrier to system improvements, due to the majority of patients being in the lower socioeconomic demographic group. Furthermore, social determinants of health play a substantial role in achieving health care system improvement.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Transforming the Arkansas Health Care System offer a promising area for exploration. Specifically, the Arkansas Community Health Centers provide a proven solution for health care systems that have already demonstrated that this model works through provision of comprehensive, affordable, and preventive services. Arkansas CHCs' embody the patient-centered medical home concepts and are moving toward the National Center for Quality Assurance recognition, which ensures that patients have a continuous 24/7 source of care, integrated health care team, and comprehensive approach that will lower the costs of care within the health care system.

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Sip Mouden, CEO; Brett Tracy, Health IT/Research Director

COMPANY:
Community Health Centers of Arkansas, Inc.

ADDRESS:
420 West 4th Street, Suite A

CITY:
North Little Rock

ZIP:
72114

EMAIL:
btracy@chc-ar.org

PHONE NUMBER:
501-374-8225

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < 84 / 100 > >| 84 GO

Payment Reform Stakeholder Survey

Individual Responses

|< < 85 / 100 > >| 85 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

In Home Health and Personal Care we see a large number of patients who are already suffering the effects of chronic conditions. Chronic disease management has real promise in the home particularly coupled with telehealth. Currently there is no reimbursement for the service and the home monitoring equipment is expensive. While prevention is important for stemming the tide of chronic disease, we still have the issues of dealing with those patients who are ill today. Patient compliance is a real issue. The provider can only do so much.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

In addition to chronic disease and related health problems, we treat a lot of wounds. Very expensive and can result in repeated hospital admissions. We have begun a new wound managament program in the home that is showing great promise and good outcomes.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

From the home health perspective, we would recommend that Medicaid adopt the episodic Medicare Home Health model. All agencies have been under prospective payment for a number of years, we use a standardized assessment document, and outcomes are reported. It would be very easy to convert Medicaid to the Medicare model. Medicaid home health is not a large percentage of the Medicaid budget. Most of the Medicaid home health patients have chronic illnesses. Providers have already spent much time and resources implementing the new Medicare changes that are part of the Affordable Care Act. It would be much less disruptive to providers and probably cost them less to convert all home health to the Medicare model.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

One issue that is unique to home health and other home and community based services is the cost of travel. We see most of the patients who live in remote rural areas of the state. Travel is an big expense both from a time spent traveling to the cost of reimbursing staff. The tendency is for providers to "cherry" pick patients when there is a lot of travel involved - particularly if the patient is going to require a lot of visits. Reimbursement must take into account these sorts of expenses or access to care in rural and remote Arkansas will be a big issue. Home Health is a labor intensive service. Nurses, aides, therapists are all hands on in the home.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Converting Medicaid home health to the Medicare model. Could be done quickly with little disruption to providers and no real impact on medicaid clients. Having a uniform system of home health services makes a lot of sense.

6. Please provide any other comments, solutions or suggestions you would like captured.

The real challenge is how to deal with the disable and long term care in the home. These patients are most likely going to require care until they go to a nursing home or die. It may not fit an episodic payment system like home health.

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 85 / 100 > >| 85 GO

Payment Reform Stakeholder Survey

Individual Responses

|< < 86 / 100 > >| 86 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Due to the high incidence of dx and high level of readmission to hospitals, consider adding pneumonia and other respiratory infections and acute myocardial infarction (AMI) to the list.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Secondly, Cerebral vascular accident (CVA) is another high cost for multiple hospitalizations and rehabilitation.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

SOURCE - Enhanced Primary Care Case Management and Care Transitions Programs - more home and community based services involving guidance, teaching and support to link and increase effectiveness of communication between patients and doctors, hospitals, and after-care providers as well as education and support to the patient and family recognizing the importance of the responsibility of informal caregivers. Increase appropriate use of emergency rooms, decrease hospital readmissions, increase client self direction and responsibility for care outcomes.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

No - other than approving the programs and providing the funding which should represent a significfant increase in the value of the medicaid funding.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Represents the medical home philosophy bringing together the community of providers. Creates movement toward bulding the healthcare "system" versus continuing with fragmented services and minimal communication.

6. Please provide any other comments, solutions or suggestions you would like captured.

Carefully examine cost savings of providing community based services (long term care) and ensure increased quality and savings before changing the system of care. State and provider cooperation on the rate setting.

7. Please indicate which response best represents you.

Other, please specify
Area Agency on Aging

8. Please select your county of residence:

Boone

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Mary Patrick/Dennise Pollyea

COMPANY:
Area Agency on Aging of Northwest Arkansas

ADDRESS:
P.O. Box 1795

CITY:
Harrison

ZIP:
72602

EMAIL:
dpollyea@aaanwar.org

PHONE NUMBER:
870 741 1144

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 87 / 100 > >| 87 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Diabetes, hypertension, COPD and CHF are the most frequent diagnosis for ED visits and hospitalizations due to deliberate non-compliance issues by the patient. Physicians and hospitals should not be penalized for non-compliance to the medical treatment plan. Often, these patients represent the same segment of our society that does not provide their own basic needs such as housing and food so why do we think they can manage chronic disease.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

End of life care. Instead of hospitals being required to ask if a patient has an advanced directive, change the requirement to having to have an advanced directive if you are a Medicare or Medicaid recipient so the burden of healthcare decisions at the end of life are not placed on someone other than the patient. Physicians and hospitals have no choice but to aggressively treat nursing home patients who are admitted to the hospital and do not have a code status in writing and being able to obtain such information from family members is very difficult. This aggressive medical treatment does not improve the quality of life; it just extends longevity of life in a nursing home.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Revamp public health services provided through local health departments so that Medicaid recipients have a medical home to monitor patient's conditions and compliance with the medical treatment plan. Staff them with PAs and Nurse Practitioners under the supervision of a medical director who collaboratively develops evidence-based treatment protocols for each condition. This mechanism would form the foundation for treatment of chronic disease. Primary care physicians would become the second level of care in the process. Given the cost of real estate for hospitals, they should be the last location considered for clinics treating chronic disease. Patients being discharged from hospitals would have a medical home to be discharged to which should reduce the rate of readmissions. I think Medicaid reform provides a tremendous opportunity to revamp the role of the health department for treatment of chronic disease.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Implement a pre-certification process based on medical necessity for ordering tests and procedures for Medicaid recipients. This process works well for reducing unnecessary duplication of resources for the commercially-insured patient. ER physicians and the hospitals they staff are in a no win situation when it comes to liability. They will continue to practice defensive medicine because of the litigation risk for failure to diagnose any condition, not just the medical emergencies. Patients who are not going to pay any out-of-pocket expenses anyway could care less about over-utilization of resources. Use EMR to allow physicians to determine when was the last time a test or procedure was performed and to review the results. Monitor utilization of resources per recipient and intervene to correct over-utiliztion resources.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

The role of the health department cannot be emphasized enough regarding the treatment of chronic disease. It should be the foundation of public health. Reform provides the opportunity to develop an integrated approach for the first time in decades.

6. Please provide any other comments, solutions or suggestions you would like captured.

Poly pharmacy is a huge issue in our society. Why are we allowing direct marketing of medications that require a prescription? It sends the message that everyone should awake from a good night's sleep, with a smile on your face and have sex on demand, otherwise, there is a pill to fix the problem! There has not been research on the complications associated with taking five or more prescription meds on a daily basis which does not even include the effects of over-the-counter medications that may be taken in addition to prescription drugs.

7. Please indicate which response best represents you.

Other, please specify
Hospital Administrator

8. Please select your county of residence:

Howard

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Debra Wright, MS, RN

COMPANY:
Howard Memorial Hospital

ADDRESS:
130 Medical Circle

CITY:
Nashville

ZIP:
71852

EMAIL:
debraw@howardmemorial.com

PHONE NUMBER:
870 845-8004

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 87 / 100 > >| 87 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 88 / 100 > >| 88 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

N/A

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

2. Address End of Life Care via information and education. Patients who have a terminal illness should be informed about all of their treatment options, including hospice. If patients and their families receive information & education, they could make informed decisions about their care and quality of life. Patients forgoing curative treatment for hospice care would save the Medicaid program from cost associated with futile care. Studies, such as the Milliman USA Study found that state Medicaid programs saves roughly $7,000 per eligible beneficiary (Hospice Care for Poor Saves Medicaid Dollars, Jane Erikson). Hospice services are a set of comprehensive core services and therefore help conserve financial resources: 1. reducing hospitalizations 2. emergency room visits 3. saving on medications and medical equipment 4. nursing home room and board

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

3. Encourage a line of better communication from the physicians regarding treatment options for terminally ill patients. For example, years ago Nancy De Parle, former CMS Director (known as HCFA at the time), educated physicians on the under utilization of hospice services and its benefits. Arkansas Medicaid leadership could do something similar. Implement Concurrent Care for Children as part of the Affordable Care Act (provision effective March 23, 2010). In addition, Medicaid could also encourage Advance Care Planning similar to Medicare and cover voluntary discussions just as Medicare does (as of January 1, 2008). For those who are concern that Advance Care Planning will ration care or hasten death, Donald Schumacher, National Hospice and Palliative Care Organization Director, reminds us that Advance Care Planning as is not about limiting or rationing care, it is about the patient making choices and communicating them. It includes completing a will and appointing a health care proxy. The course charted is decided by individual patients, not their doctors, and certainly not the government.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

4. There are opportunities that could be put in place to overcome current barriers such as edits and audits in the Medicaid system to save money. We do not expect there is intentional fraud or abuse on the part of hospice providers, but changes similar to those CMS has in place could save the Arkansas Medicaid program money. This was pointed out in the HPCAA (ASHPCA) Recommendations for Changes to Arkansas Medicaid Hospice Benefit when Medicaid solicited comments last year from all providers concerning the Medicaid Cost Curve. For example, the HPCAA (ASHPCA) association pointed out, if the EDS system could be modified with edits similar to those put in place by CMS, any patient receiving hospice paid by Medicaid could not access other services/treatments without it being denied. This would ensure that treatments related to the terminal illness such as diagnostics, medications, etc., be billed to the hospice provider and not the Medicaid program.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

5. Hospice studies have proven that it is cost effective and it is the golden standard for end of life care. While there are local coverage guidelines, it has been stated over and over, prognostication is not an exact science. The guidelines are just that, guidelines. Some patients live less than 6 months and some longer. No two patients with the same condition tend to run the same course. The

certification of terminal illness, clearly states, 6 months or less if it runs its normal courses.

6. Please provide any other comments, solutions or suggestions you would like captured.

N/A

7. Please indicate which response best represents you.

Other, please specify
Hospice

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Gayla Lanum

COMPANY:
Arkansas Department of Health Hospice

ADDRESS:
5800 West 10th Street

ADDRESS 2:
Suite 300

CITY:
Little Rock

ZIP:
72204

EMAIL:
Gayla.Lanum@arkansas.gov

PHONE NUMBER:
501-661-2698

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < 88 / 100 > >| 88 GO

Payment Reform Stakeholder Survey

Individual Responses

|< < 89 / 100 > >| 89 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

• Diabetes Annual Inpatient Volume 50 Average LOS 3.5 days Readmission Rate 32% • Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Annual Inpatient Volume 6 Average LOS 3.0 days Readmission Rate 0% • Chronic Obstructive Pulmonary Disease Annual Inpatient Volume 40 Average LOS 8.2 days Readmission Rate 28% JRMC experiences a higher occurrence of COPD than the calculated 3M expected rate and comparison peer groups. Incentives for home care treatment and follow-up are needed. • Congestive Heart Failure Annual Inpatient Volume 37 Average LOS 3.5 days Readmission Rate 23% • Pregnancy/Delivery: C-section, timing of delivery Annual C-Sections 243 Annual Vaginal Birth 465 Annual Neonate 791 • Neonatal Intensive Care Unit (NICU) care – JRMC does not have a neonatologist on staff and critical cases are transferred to Little Rock. • Outpatient Infections (ear infection, urinary tract infections) 50% of JRMC's "non-emergent" emergency room visits consist of common conditions such as ear infections, upper respiratory infections, stomach or flank pain, etc. • Activities of Daily Living (ADL's) - supportive care/appropriate location of care – JRMC utilizes alternate services such as the Area Agency on Aging, Home Health, etc.. to address the needs of patients. • Preventive Care JRMC provides a great deal of post visit follow-up and care coordination for things such as medication assistance, coordination for financial assistance for utilities and daily living needs, transportation, etc.... • Mental Health/Behavioral Health JRMC has a higher percentage of bi-polar and schizophrenia than the calculated expected and peer groups. • Developmental/Intellectual Disabilities - No recommendations • Ischemic Heart Disease – No recommendations

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

While most of the statistics on JRMC's Medicaid population align with the disease topics on the survey, the areas that our team has identified which need to be addressed in any Medicaid reform program are: 1) maternal-fetal care; 2) psychiatric and other mental disorders; and 3) enhanced access to primary care or urgent care. These three areas are the top consumers of services for our facility, while the remaining inpatients are widely distributed with various diagnoses in small numbers. Outpatient services are overwhelmed with non-emergent visits, which should normally be treated by a primary care physician or urgent care facility. Based on analysis of our data JRMC offers the following suggestions for consideration in the transformation of the Medicaid program. • The State should consider implementing both urgent care clinics as well as "medical homes" in communities such as ours to avoid the current overloading of emergency rooms with non-emergent medical problems. • The State should consider a change to replicate the rules for observation to follow those used by Medicare, which allows up to 48 hours when necessary and medically appropriate. Medicaid patients have a higher percentage of care coordination / financial / transportation issues than the general populations, which impacts early discharge from the hospital. Because of inadequate time for care coordination, education, and arrangements for post-acute care, the 24-hour limit does not allow for adequate coordination of treatment leading to potentially inappropriate assignment to Inpatient status on short stays (1-2 days). • Follow-up care and compliance with home care needs and medications is critical, and the new "medical home" concept should provide a significant incentive for some component of providers to become engaged in follow up interaction with the patients. Access to primary care physicians is difficult, particularly in JRMC's primary and secondary service areas. The number of treating physicians does not adequately cover the population. Socio-economic conditions (i.e. ability to pay for medications or transportation) also impact follow-up treatments and compliance with home care needs. • Medicaid should consider offering increased incentives to patients and physicians for prenatal care and wellness programs. Pregnant mothers are not getting the prenatal care needed and many present for delivery with little or no previous care. Enhanced substance abuse programs should target this particular vulnerable population, as our experience indicates a much higher percentage of expectant mothers addicted to various alcohol and drug products, when compared to our control population of non-Medicaid mothers. • The State should consider expanding the focus of the current Medicaid P4P Incentive Program to increase the focus on care coordination. Hospitals that are high performers should receive additional incentives. Utilization of evidence-based treatment/care plans should be measured and rewarded. • The existing transportation services available to the Medicaid population of southeast Arkansas are difficult to access, leaving the hospitals with the challenge of timely discharges. Vouchers for non-emergency transportation or additional providers of transportation services are needed in order to avoid unnecessary additional patient days. • There is a gap in the overall continuum of care of patients with the restriction of coverage for specific services, such as

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

no response

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

• Financial commitment and funding by the State • Participation by primary care physicians

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Increased access to services

6. Please provide any other comments, solutions or suggestions you would like captured.

No recommendations

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

Jefferson

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Walter Johnson, CEO

COMPANY:
Jefferson Regional Medical Center

ADDRESS:
1600 W 40th Avenue

CITY:
Pine Bluff, AR

ZIP:
71603

EMAIL:
johnsonw@jrmc.org

PHONE NUMBER:
870.541.7822

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < 89 / 100 > >| 89 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 90 / 100 > >| 90 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Mental/Behavioral Health

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

a) Identify redundant processes from National Accreditation bodies and include results from those audits into the state's audit information compilation, deferring to audit results from audits already conducted. b) Implement a whole-person and well care planning model by integrating the common functions and all common processes in relation to all service delivery areas. c) Streamline and integrate audit process across all DHS umbrella agencies. (CCL, DBHS, Medicaid, AFMC, Value Options, Dept Health, Q-Source etc)

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

a) Take the following action steps to integrate common functions and processes: a. create an environment of a single licensing/certification entity, b. create a single prescription to document medical necessity for provision of services, c. consolidation of service documentation and redundancies of paperwork across service delivery programs, d. create an integrated treatment planning process and treatment planning document for multiple programs in a single client planning process (whole person planning); e. a single billing process to permit integrated client billing that incorporates multiple Medicaid programs to be rendered in a single submission; f. Flexibility about how billing data is processed and analyzed so that detailed statistical information can be reviewed and aggregated. b) These suggestions would a. enable the use of clinical outcomes data for benchmarking, improving care and cost reduction.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

a) Lack of emphasis and reimbursement for wellness strategies. b) Systems that works in silos and independently that do not encourage integrated care for the whole person c) Lack of HIT assistance d) Lack of transportation e) Need for meaningful, real-time data from Medicaid f) Lack of centralized eligibility for all social services, e.g., Medicaid, TEFRA, AFDC, Food Stamps, WIC, etc.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

a) The existence of this review process indicates that there is a desire to improve overall states of public health in Arkansas, to reduce costs, and to improve efficiency.

6. Please provide any other comments, solutions or suggestions you would like captured.

None

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

Craighead

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Dan Sullivan

COMPANY:
Arkansas Behavioral Health Providers Association

ADDRESS:
3012 Turman Dr

CITY:
Jonesboro

ZIP:
72404

EMAIL:
dan.sullivan@ascentchs.com

PHONE NUMBER:
870-897-7117

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < 90 / 100 > >| 90 GO

Payment Reform Stakeholder Survey

Individual Responses

|< < 91 / 100 > >| 91 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure, pneumonia, serious mental illness, and other chronic conditions. Five conditions --pneumonia, congestive heart failure, urinary tract infections, dehydration, and chronic obstructive pulmonary disease/asthma-- were responsible for 78% of the potentially avoidable hospitalizations across settings under Medicaid. (CMS Aug. 2010) Two mental health conditions ranked among the top ten most frequent reasons for Medicaid hospitalizations—mood disorders and schizophrenia and other psychotic disorders. (AHRQ.) People with all of these conditions can avoid hospitalizations if they can obtain the structured, consistent care offered in ALFs/RCFs.)

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

a) Use SSA 1915(i), Innovation Waiver, or other authority to increase eligibility in assisted living facilities (ALFs) and residential care facilities (RCFs) to 300% of SSI, the same as for nursing homes. Target the population suffering from chronic disease. This will effect positive change by reducing hospitalization and institutional care costs, improving quality and reducing costs. b) Create complete transparency in MMIS data, providing real-time data to providers at both the individual and big-picture "enterprise" level. This will enable the collection and use of clinical outcomes data for benchmarking, improving care, and reducing costs.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

a) If a person makes more than 150% FPL, they can qualify for nursing home care but not personal care (assistance with ADLs) in an ALF/RCF. b) The ALF waiver ("Living Choices") would be helpful for elderly who want to live in ALFs/RCFs, but the state has authorized very few waiver slots and is too restrictive in its medical eligibility criteria. c) There is no waiver-type program for people with chronic mental illness and other disabilities who wish to reside in RCFs/ALFs. d) Meaningful claims data is not available to providers. e) Lack of Health Information Technology assistance. f) Lack of effective transportation – broker system is disconnected from care delivery. g) Lack of centralized eligibility for all social services, e.g., Medicaid, TEFRA, AFDC, Food Stamps, WIC, etc.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

ALFs/RCFs have already demonstrated that they are able to keep people out of the hospital and care for them much more efficiently. People with these chronic diseases go from several hospitalizations to none when they are in a structured environment like an ALF/RCF. It costs an average nationally (as reported by CMS) of $8,168 per avoidable hospital stay, with many beneficiaries being hospitalized several times during a year. In Arkansas, the average cost of all acute and rehab hospitalizations is $,5608 per beneficiary and $24,094 per beneficiary for inpatient psych hospitalizations. The average cost of Medicaid Personal Care is $5,410 (compared to $37,000 for nursing home care and $29,617 for home-and-community-based waivers). If an ALF/RCF can prevent even one hospitalization, the savings more than cover a year's worth of services in the ALF/RCF.

6. Please provide any other comments, solutions or suggestions you would like captured.

None.

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

Lonoke

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Kent Schroeder

COMPANY:
Arkansas Residential Assisted Living Association

ADDRESS:
692 Honeysuckle Lane

CITY:
Cabot

ZIP:
72023

EMAIL:
kentschroeder@classicnet.net

PHONE NUMBER:
501-941-2072

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < **91** / 100 > >| 91 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 92 / 100 > >| 92 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Prevention and a focus on wellness will create cost savings. Preventing diabetes, Hypertension, COPD, congetive heart failure and the need for neonatal intensive care units is the best cost saving swe can provide. Using a model of care that provides a model of care that is integrated with a team approach to pateint care is a model that willsave money. The use of an EHR will demonstrate improvements pateints make and reduce health dispariites. Cost savings for Medicaid and private insurances companies will come from fewer hospitalizations, less inappropriate use of the emergency rooms and less referrals to speciality care providers. High inefficiencies result from rationing caer to just a few.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Improved ways to share medical records (HIE) will result in fewere duplication of lab tests, x-rays, and other diagnostic tests, as well as improved care after hospitalization when care goes back to the primary care provider. Integrating behavioral health in a primary care settign will also reduce cost by giving pateints tools to make changes in behavior before this behaviors creates a chronic condition.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Care should be available to all.Diabetes -- allow diabetic pateints to access diabetic education and nutritional education programs. Pay for this care. It will result in more compliant pateints and less cost to the health care system overall to address problems early. Care and educatiuon should be cultually and linguistically appropriate to the patient.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Childrena nd their families who are in Arkansas LEGALLY must currently wait 5 years to qualify for Arkids 1st. It costs us more to treat their avoidable diseases and complications of a lack of care that to provide care sooner. Close this gap. The renewal process for Arkids 1st results in wasted tiem for processing and duplication of efforts. Continue to offer care in non-tradtional settings like schools with the schools based health centers which connect families to the health system.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Prevention and wellness is our best investment for lower healthcare cost. Don't overlook this in attempt to make huge savings in our system. New approaches with data that shows an improvemnt such as integrated behavorial health in primary care is a new approach that has data to support its use for savings and improvemnt of pateints care.

6. Please provide any other comments, solutions or suggestions you would like captured.

We can not overlook the social determinates of health and our responsibility to address them. Education is one of the keys to overcome them. Tansportation is another area that must be addressed if we are to prove care to low income Arkansans who experience many chronic diseases.

7. Please indicate which response best represents you.

Health System Administrator

8. Please select your county of residence:

Washington

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Kathy Grisham

COMPANY:
St Francis House NWA, Inc DBA Community Clinic

ADDRESS:
614 E Emma Suite 300

CITY:
Springdale

ZIP:
72764

EMAIL:
kgrisham@communityclinicnwa.org

PHONE NUMBER:
479-601-2006

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 92 / 100 > >| 92 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 93 / 100 > >| 93 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

We should also look at new areas of preventive care that could produce savings. These could include financial incentives for PCPs to use evidence-based developmental screening tools as part of EPSDT, reimbursing physicians to apply fluoride varnish, and possible populations that could benefit from better access to preventive care. For example, we have roughly 1000 legal immigrant children, including Marshallese, who could benefit from access to preventive care under ARKids First of the state removed the 5 year ban (a new option under CHIPRA). It may be possible to look at, for example, cost data from providers who serve these populations and see what the cost offsets might be when we are able to get them preventive care with a federal match.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

We hope the working groups in each area will closely study handoffs between providers, especially a detailed look at the the referral process for any of these areas to see what happens to care quality and access when lags occur. There may be ways to improve coordination and communication among providers --hopefully through better use of technology and EMRs --that could make the processes more efficient. It should be done in a way that ensures PCPs feel confident about the referral and timing and specialists have the ability to effectively convey the need for certain services. the process should also allow for some sort of dialogue or communication when the parties do not agree that gets to a quick resolution. Any new process should absolutely ensure shared accountability and quality. Similarly we can't ignore the problems of enrollment/coverage stability on ARKids and Medicaid. We hear from providers often about kids who drop off and don't find out until they show up for a prescription or appointment. That also costs money as kids come on and off. We can make it easier to keep kids enrolled through better use of technology.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

We need a robust HIE system that allows for a good exchange of health related information among providers that will ultimately serve to facilitate better quality care for consumers.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

6. Please provide any other comments, solutions or suggestions you would like captured.

Areas of inefficiency that cannot be ignored include: - Opportunities to better serve many recipients (Seniors, DDS, mental health system) in communities rather than bed-based settings. - Opportunities to offer preventive care in new settings and reach children/families who are not connected to a medical home (e.g. schools) and bring them into the health system. - Wasted time/process/duplication that occurs with referrals, provider "handoffs" etc. - Lack of preventive care/coverage for children and their parents, especially lack of coverage availability for legal immigrant children, particularly the Marshallese (state option to remove the 5 year bar that exists for legal immigrant kids), who cost taxpayers more as they are treated for avoidable disease or complications - Red tape and cumbersome processes that hinder enrollment and *ESPECIALLY* renewals, where thousands of kids drop off and then cost the system more as they churn on and off coverage. Technology could play an important positive role here, not to mention in coordinating service systems and health care providers. - New opportunities to provide preventive dental care to kids (e.g.

physicians), as was authorized during the recent legislative session

7. Please indicate which response best represents you.

Consumer/Patient

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Elisabeth Wright Burak

COMPANY:
Arkansas Advocates for Children and Families

ADDRESS:
Suite 306

ADDRESS 2:
1200

CITY:
Little Rock

ZIP:
72201

EMAIL:
eburak@aradvocates.org

PHONE NUMBER:
501-993-1585

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < 93 / 100 > >| 93 GO

Payment Reform Stakeholder Survey

Individual Responses

|< < 94 / 100 > >| 94 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Data regarding urinary incontinence should be analyzed. It may be that if UI could be managed better at home, then admission to nursing homes could be delayed. Reimbursement for incontinence supplies could be a surrugate for determining prevalence rates. Also, we need to analyze the data related to Alzheimer's Disease. Many people with AD could stay out of institutional care if the right kind of community-based services were available. Also, we need to make it possible for more new mothers to receive home visitation services to assure they have the health literacy skills they need to manage their chronic conditions as well as the health of their babies. They also need health literacy skills to delay their next pregnancy.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Many of the items discussed above are chronic conditions that Arkansans need self-management training for. The Stanford Chronic Disease Self-Management Program is a basic health literacy programn that is evidence-based and has been demonstrated to reduce emergency department use,number of hospitalizations as well as length of stays. It was shown to save 4 health care dollars for every dollar spent implementing it. It's success does not depend on the participants being able to read, which is an important consideration for many Arkansans, who stuggle with reading.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Reimbursement for providing patient self-management training is lacking. We also need funding for health care agencies to do electronic remote home-monitoring of their patients while they are learning self-management skills.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

The Stanford Chronic Disease Self-management program is provided in 2.5 hr sessions for 6 weeks in group settings. It uses trained lay leaders, which are less costly and avoids the health care provider shortage. We have master trainers already in Arkansas through the AAAs and Centers on Aging.

6. Please provide any other comments, solutions or suggestions you would like captured.

Health literacy interventions in the form of evidence-based programs that increase a patient's ability to management their personal (or their family members') health exist and should be utilized in Arkansas. Home visiting and chronic disease self-management are two of the best examples that have solid evidence for decreasing costs and improving outcomes. They already exist in Arkansas and could easily be expanded if reimbursement were sufficient.

7. Please indicate which response best represents you.

Other, please specify
state government

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Jennifer Dillaha, MD

COMPANY:
Arkansas Department of Health

ADDRESS:
4815 West Markham Street, Slot 39

CITY:
Little Rock

ZIP:
72205

EMAIL:
Jennifer.Dillaha@Arkansas.gov

PHONE NUMBER:
501-661-2864

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < 94 / 100 > >| 94 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 95 / 100 > >| 95 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

I support they way you have identified areas where the state has the potential to reduce duplications, save $. To me, it is a good approach. I also really appreciate the fact that we are starting with and making decisions by looking at data.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

long term care. Our processes and systems in Arkansas create an institual bias that forces people who could receive their care at home into institutions.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

We support a universal assessment. However, I don't think that will be enough. We will need to continue to look at all our processes (EX: It takes longer to get approved for home care than nursing home care)to give people access to less expensive home and community based care.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Yes. See example above. Also, we cap the number of people who can be served in home and community based programs but do not cap the number of people who can receive nursing home care.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Continued work on the eligibility and application process (that starts and frequently stalls at the local DHS office). Continued work on a uniform assessment process. A careful and thorough look at all the ways home and community based programs are capped compared to nursing home care.

6. Please provide any other comments, solutions or suggestions you would like captured.

I congradulate you on your evaluation of diagnosis codes, etc. As important as the high level evaluations are, getting down in the mud and looking at DHS process will be equally important. Over the years, DHS processes have been at least as big a factor in creating an institutional basis as Medicaid regulations (EX: nursing home a mandated service) and political factors.

7. Please indicate which response best represents you.

Other, please specify
AAA

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Elaine Eubank

COMPANY:
CareLink

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

|< < 95 / 100 > >| 95 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 96 / 100 > >| 96 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

For Mental Health, start with totally revamping the leadership and structure of the Division. Recognize that mental health is a significant factor that is critical to the mangement, treatment, and prevention of every priority area on the list. Implement policiues and systems that support mental health parity. Recognize that addictive diseases affect the management,treatment, and prevention of all diseases.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Addictive disease mental health

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Educate health care policy makers regarding the impact of mental health and addictive disease onh health management Train primary care providers to recognize and treat mental illness and addictive disease. Effective treatment will improve the overall health of Arkansans and lead to better outcomes in the management of all health issues with resulting cost savings

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Leadership in the state healthcare system. Lack of knowledge, misinformation and bias toward mental health and addictive disease

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Because current systems provide barriers to treatment and studies consistently demonstrate that mental illness and addictive disease is under diagnosed and under treated if treated at all

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 96 / 100 > >| 96 GO

Payment Reform Stakeholder Survey

Individual Responses

|< < 97 / 100 > >| 97 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Mental health/behavioral health

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Two recommendations: 1. It is recommended that behavioral health facilities be permitted to receive reimbursement for adult Medicaid patients. This suggestion is not without precedent, with other states having already made this transition. The IMD standard made a lot of sense in the 1960s; however, much has changed since that time. Acute hospitals now receive more than $800 per diem for adult Medicaid patients. Even if freestanding psychiatric hospitals received a rate consistent with the Medicare PPS rate, that would be a reduction of more than $150 to $200 per patient per day for the state Medicaid system. On a 5 day LOS, allowing reimbursement for psychiatric facilities would save the state between $750 and $1000 per hospitalization while maintaining a high quality of care. In a cost containment environment, this has been a great strategy utilized by other states to bend the cost curve. 2. It is recommended that Arkansas's children and adolescent patients with Medicaid receive services in Arkansas for behavioral health/mental health services. This position is for several reasons: (1) active treatment standard: since a component of active treatment requires family involvement, it is ideal to provide active treatment as close to their community as possible; (2) continuity of care from inpatient to outpatient services in the state provider network where collaboration is more frequent translates into improved care; and (3)economic impact on Arkansas' communities: it is a concern that Arkansas' healthcare professionals are unable to work due to low census in Arkansas facilities while children and adolescent Arkansans are sent to MS, TN, LA, MO, OK, and TX for treatment. Those dollars contribute an economic impact to those communities outside of Arkansas at the expense of communities within Arkansas. There are two exeptions to this standard tht may allow these children and adolescents to be transported over state lines for services in the event all facilities in Arkansas are at capacity or require specialty services not available in Arkansas. In the absence of those special circumstances, those services should be provided in Arkansas.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

The Feds are requesting applications for IMD waivers from states. There is money available for a demonstration project. If anything, it will improve continuity of care for these patients, eliminating this hole in the current service delivery system for adult Medicaid patients. There are no barriers in the current system that would interfere with Arkansas children and adolescents to be treated in Arkansas with the exception of special circumstances (special population, Arkansas' facilities at capacity).

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Major cost driver while maintaining quality services. The inpatient psychiatric hospitals are already equipped to provide this continuity. As mentioned, this has been done in other states with cost savings and no reduction in quality care. With regard to the transporting of Arkansans over state lines, surveying current providers in Arkansas to determine the extent of availability to provide additional capacity for these children and adolescents.

6. Please provide any other comments, solutions or suggestions you would like captured.

Allowing free standing psychiatric facilities to provide services to adult Medicaid patients would also allow med-surg hospitals not to have med-surg beds filled with psychiatric patients when patients require med-surg services.

7. Please indicate which response best represents you.

Other, please specify

8. Please select your county of residence:

Pulaski

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 97 / 100 > >| 97 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 98 / 100 > >| 98 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

I believe payment reform is essential to serving more patients and decreasing the cost of health care. Medical homes are a key way to provide population based care that is more effective.The chronic diseases listed are more effectively managed in this model. Medical homes provide better access to care, high quality services and decreased cost. Patient centered care will be critical in providing these services. The use of integrated teams to address health issues is proven to be very effective. Integrated behavioral health has proven to identify patients who are presenting to their primary care office with physical complaints when untreated behavioral issues are at the root of the problem. In this model more patients are receiving the services they need in order to lead healthier lives. The use of the patient centered medical home model will decrease unnecessary hospitalizations, decrease emergency room visits, and decrease the inappropriate referrals to specialty care.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

I believe the in order to decrease health care costs the state of Arkansas must support integrated primary care behavioral health and put an emphasis on wellness and preventative services, and utilize patient centered medical homes.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

I believe we need to provided population based using a holistic approach and treating the patient in one medical home with referrals to specialty care that are necessary. Providing integrated primary care behavioral services in medical homes will be critical to addressing all of the patients needs and treating the whole person in one location. We know that primary care medical homes have become the "defacto mental system" and that is where patients go to receive all care.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Yes there are barriers to care . There is a lack of preventative care,a lack of care to legal immigrant children, health disparities and lack of coverage for the Marshallese residents. People who can't access care have no choice but to go the ER for healthcare. Their needs could be addressed much more cost effectively through providing them access to affordable care. Patients often do not seek out specialty services when referrals are made.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Medical homes that are patient centered providing holistic care through providing integrated services.

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

Washington

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

NAME:
Kim Shuler

COMPANY:
Community Clinic

ADDRESS:
614 East Emma Suite 300

CITY:
Springdale

ZIP:
72703

EMAIL:
kshuler@communityclinicnwa.org

PHONE NUMBER:
479-751-7417 x 6072

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 98 / 100 > >| 98 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 99 / 100 > >| 99 GO

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

Provide incentives to those who manage their chronic diseases.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Active treatment for mental health must be evident. e.g. how can family involvement occur if a child is out of state? Allow private psych hospitals to provide services to adults with Medicaid. Less expensive

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.

No, please do not post my name or contact information with my response(s)

|< < 99 / 100 > >| 99 GO

Payment Reform Stakeholder Survey

« Return to Survey Results

Individual Responses

|< < 100 / 100 > >| 100 go

At the stakeholder meeting on May 26th, the items listed below were presented as potential priority areas. Please use this survey opportunity to provide feedback on those areas AND suggest additional areas where you see inefficiencies in the care or treatment of specific diseases or conditions.

Please submit responses through this secure survey tool by JUNE 30, 2011.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting. Diabetes Hypertension (comparative effectiveness and use of ACE inhibitors vs. ARB for treatment) Chronic Obstructive Pulmonary Disease Congestive Heart Failure Pregnancy/Delivery: C-section, timing of delivery Neonatal Intensive Care Unit (NICU) care Outpatient Infections (ear infection, urinary tract infections) Activities of Daily Living (ADL's) - supportive care/appropriate location of care Preventive Care Mental Health/Behavioral Health Developmental/Intellectual Disabilities Ischemic Heart Disease

The majority of our patients have these top four diseases: Diabetes, Hypertension, COPD, and/or CHF. We provide lots of teaching on these areas.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Obesity prevention has not been a major health focus. Our society tend to wait until this disease is out of control and it tends to lead to the top four diseases.

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Preventative methods need to be more the focus in children and young adilts. We need to focus on healthy living and healthy lifestyles.

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Yes, the focus should be on preventative health.

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Early education and prevention will produce long healthy living and decrease medical costs.

6. Please provide any other comments, solutions or suggestions you would like captured.

7. Please indicate which response best represents you.

Medical provider – (Inpatient, Outpatient, Emergency Room, Primary care, Specialist, dental, mental health, nurse, etc.)

8. Please select your county of residence:

Jefferson

9. Please supply your contact information if you would like to be added to the stakeholder distribution list*. *If you prefer not to provide identifying information with your survey responses, please email Patsy.Wallace@arkansas.gov to be added to the list.

10. All survey responses will be posted on the Arkansas Department of Human Services webpage. If you do not want your contact information posted with your response, please indicate below.